House Committee on Ways and Means, Subcommittee on Oversight
Question for the Record and Response from
Dr. Peter Budetti, Director, Center for Program Integrity
Center for Medicare & Medicaid Services

Chairman Boustany, Jr.

The Inspector General has reported that when 1,500 durable medical equipment suppliers were subject to unannounced site visits in 2007, nearly a third were found to fail basic Medicare standards and were kicked out of the program. A lot of these providers appealed their revocations, and 91 percent were reinstated and allowed to bill Medicare again. Of these suppliers, as many as two-thirds have had their billing privileges revoked again, and many have been indicted for health care fraud. It is unclear by what standards good suppliers are allowed to stay *in* the system and bad ones are kept *out*. The Office of Inspector General has suggested that CMS develop better criteria on the types of evidence necessary to reinstate billing privileges so that there is more consistency in the system.

Question: What has your agency done, if anything, to remedy this problem? If no progress has taken place, why not? Please provide copies of the current evidentiary criteria used in these cases.

Answer: With respect to the 1,500 revocations in question, a substantial number of these were overturned because it was later determined by ALJ hearing officers that the initial evidence of the supplier's non-operational status would be insufficient to withstand an appeal at the Administrative Law Judge (ALJ) level. However, CMS has taken multiple steps to address the concerns identified by the OIG in 2008. In 2009, CMS began to require accreditation for DMEPOS suppliers; additionally CMS implemented a final rule in 2008 to address the high rates of revocations overturned on appeal by implementing a process that permits reconsideration and requires DMEPOS suppliers to submit evidence much earlier in the process. This led to a decrease from 118,000 DMEPOS suppliers in 2007 to 95,000 in early 2009. Largely as a result of these new requirements, 16,000 suppliers did not enroll in Medicare, an additional 7,000 did not comply with the accreditation standards.

If a DMEPOS supplier's Medicare billing privileges are revoked, the supplier may submit a Corrective Action Plan (CAP) and/or a request for reconsideration. Both are submitted to the National Supplier Clearinghouse (NSC), the Medicare enrollment contractor for DMEPOS suppliers. The former must be submitted within 30 calendar days of the date of the revocation notice; the latter, within 60 calendar days of the date of said notice.

The CAP process gives suppliers the opportunity to correct the deficiencies that resulted in the denial or revocation of billing privileges. A CAP must contain verifiable evidence that the supplier is now in compliance with all enrollment requirements. If this can be shown, the supplier's billing privileges may be reinstated. With respect to reconsiderations, the NSC's review is limited to its initial reason for imposing a revocation at the time it issued the action and whether the Medicare contractor made the correct decision to revoke. In

other words, the review is limited to the question of whether the supplier was in compliance at the time the contractor made its decision, as opposed to whether the supplier is in compliance now. This latter standard was recently promulgated so as to prevent a supplier from being able to re-enter Medicare months after the revocation by arguing that it is now in compliance.

Your agency published a Final Rule regarding the enhanced screening requirements for providers, based on levels of risk to program integrity. The rule requires that CMS screen 20 percent of current providers and suppliers each year, so that all will have been screened by the end of 2015.

Question: Does CMS anticipate that enrollment fees will fully cover the cost of this additional screening? If the deadline will not be met, when does the agency plan to complete the screening?

Answer: The Affordable Care Act requires that the application fee be used for program integrity activities, including covering the costs of the new screening requirements. Although we do not know for certain whether the fees will be adequate to cover all costs of screening, we will monitor implementation costs closely and will assess the adequacy of the fees at a later time after we have had some experience with the new requirements. Additionally, the Affordable Care Act requires that all providers and suppliers enrolling or revalidating enrollment in Medicare be screened under the new requirements by March 23, 2013. In order to enable us to meet this deadline, we have clarified for the provider and supplier communities that CMS has the authority to require off-cycle revalidations of enrollment records that will trigger the new screening measures. State Medicaid agencies have until 2015 to ensure that Medicaid and CHIP providers and suppliers have been screened according to the new requirements.

The CMS FY 2012 budget justification includes an increase in your Center's number of full-time employees from 53 to 57 employees.

Question: Can you please provide a breakdown of the titles of all of your current employees, and the city where they are based. Also, provide an explanation of the need for four additional employees and a description of those positions.

Answer: For 2010, CPI had 51 Program Management full-time employees (FTE). Our 2011 estimated FTE level of 53 and our projected need of 57 FTE slots in our FY 2012 Budget Request are to support our ongoing work and the need for more analysts for the increased data workload, with new Congressional mandates to implement the Affordable Care Act and with existing program and systems workloads. These requested FTE levels will provide CPI with the level of staff needed to support the increased workload resulting from our work on the new authorities provided by the Affordable Care Act and other expanded Program Integrity initiatives, including the HEAT Task Force and increased HCFAC efforts.

In your written testimony, you wrote about your "strategic principles" for program integrity. The Subcommittee understands your office has hired a private contractor to develop the Center for Program Integrity's "strategic plan."

Question: Can you please provide more information on this, such as the status of the plan, the cost of the contract, and how long the plan has been in development? Is it correct the contractor is also performing other duties for your office, such as responding to comments related to Federal regulations?

Answer: The Center used an existing organizational development contract with Deloitte through the CMS Office of Human Resources and the Office of Personnel Management to help with the establishment of the new Center, including both the organizational structure and the change management required. The scope of the work for the Center under this contract consisted of three phases: Assessment, Design and Implementation. This contract was not utilized to aid CPI in any way in developing responses to comments related to Federal regulations.

The Assessment phase focused initially on interviews with internal and external stakeholders, gathering information on the existing business process, and developing internal strategic planning documents, the purpose of which was to guide organizational design efforts such as reorganizations of staff within the Center, refocusing Center activities, helping staff with culture change, and identifying key strengths and weaknesses. One of the outputs of the internal planning documents was the development of a budget spreadsheet cross walking budget activities to the Center's strategic principles and ensuring alignment of the budget and staff resources on the key strategic goals.

The Design phase analyzed existing organizational structure and business process flows and supported CPI in the redesign of our organization and business processes. The current Implementation phase includes supporting CPI in implementing the various processes and plans that have been developed thus far, including developing and utilizing project management processes and tools to ensure CPI operates efficiently.

With CPI being operational almost a year, less support is needed of Deloitte and as a result the Implementation phase is also winding down, with the contract ending in July 2011. In total, the contract cost $2.875 million.

House Committee on Ways and Means, Subcommittee on Oversight
Question for the Record and Response from
Lewis Morris, Chief Counsel, Office of Inspector General

Chairman Boustany, Jr.

Question: In your written testimony, you emphasized how critical it is for the Office of Inspector General to obtain "real-time" data on Medicare claims from CMS. Please explain what level of access is currently available. Please also elaborate on how this data could help law enforcement efforts, and what obstacles currently prevent the IG from obtaining this data.

Answer: Access to "real time" data could help law enforcement efforts by allowing agents and analysts to increase their response time once they have identified potential fraudulent billing patterns. This is especially useful when criminals shift their schemes to try to avoid detection.

Currently, the OIG has limited law enforcement access to "real time" Medicare claims data through a system called Next Generation Desktop (NGD). NGD is maintained by CMS in support of the 1-800-MEDICARE hotline. OIG is working closely with CMS to expand our access to "real time" claims data and to enhance the NGD platform to better support law enforcement purposes. The reason that our access is limited thus far is a technology issue. The infrastructure does not yet exist for OIG to get the comprehensive data access that we would like, but OIG is working closely with CMS to address this need.

In addition, OIG has access to historical claims through the national Medicare claims database, Services Tracking Analysis and Reporting System (STARS). The claims data in STARS is updated on a monthly basis. CMS has expanded its systems capacity to support broad OIG access and has trained OIG agents how to use the database.